DOCUMENT RESUME

ED 438 889 PS 025 796

AUTHOR	Barbell, Kathy
TITLE	Foster Care Today. A Briefing Paper.
INSTITUTION	Child Welfare League of America, Inc., Washington, DC.
PUB DATE	1997-00-00
NOTE	22p.
AVAILABLE FROM	Child Welfare League of America, 440 First St., N.W., Suite 310, Washington, DC 20001-2085. Tel: 202-638-2952; Fax: 202-638-4004.
PUB TYPE	Reports - Evaluative (142)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Change Agents; Change Strategies; *Child Welfare; Family Involvement; *Family Needs; Family Problems; *Foster Care; Foster Children; Foster Family; Youth Problems
IDENTIFIERS	Family Preservation Services; Family Support; Historical Background; *Systemic Change

ABSTRACT

This paper addresses the current status of foster care, how the system got that way, and the characteristics of a reconceptualized foster care system that will be responsive to today's social conditions as an integral part of broad child welfare reform. The paper begins by discussing four factors that have contributed to the dramatic increase in the number of children in foster care: (1) more reports of child abuse and neglect; (2) increasing rates of re-entry into foster care; (3) increased time that children spend in care; and (4) the impact of other service systems on the number of children and young people served by the foster care system. It goes on to explain that, in addition to the problem of increasing numbers, are the problems of emotional/behavioral disturbances, substance abuse, HIV/AIDS, medically fragile and physically handicapped children, more infants and young children, more children and youth of color, and the changing nature of foster placements, such as kinship foster care. It then explores the historical roots of the foster care system, including the issues of poverty, homelessness, alcohol and other drug abuse, HIV/AIDS, and adolescent pregnancy and parenting. The paper asserts that the system must address several critical needs: (1) the children in care with their health, mental health, and developmental and educational needs; (2) the biological families with whom the system is working; (3) an adequate number of qualified foster parents; and (4) a highly skilled staff. The paper concludes by discussing a reconceptualization of foster care based on new recognition of children's connections to and embeddedness in their families and their communities. This new recognition is discussed in terms of five themes: (1) the importance of family to children; (2) children's lifelong connections to their families; (3) the uniqueness of families; (4) the shifting availability of family members; and (5) the need to broadly define family or family-like support. The paper concludes by noting that the federal Family Preservation and Family Support Program provides an excellent vehicle for beginning the reconceptualization in light of these themes. (Contains 66 references.) (EV)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 438 889

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
X This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

FOSTER CARE TODAY

A Briefing Paper

by

Kathy Barbell
Director of Foster Care
Child Welfare League of America

440 First Street, NW, Suite 310
Washington, D.C. 20001

202-942-0282

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY
S. J. Brite
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
2B

1997

BEST COPY AVAILABLE

PS 025796

FOSTER CARE TODAY

This briefing paper addresses the current status of foster care, how we got where we are and the characteristics of a reconceptualized foster care system that will be responsive to today's social conditions as an integral part of broad child welfare reform.

Current Status of Foster Care

The Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) has been a key factor in shaping the current status of foster care. The Act responded to concerns expressed in the late 1970s that foster care placement was being used when other services would be more appropriate, that children were remaining in foster care for excessive periods of time, and that children were simply forgotten once they entered the foster care system. The Act encouraged less reliance on foster care and greater use of preventive and reunification services, and required permanency planning efforts. This mandate clearly was intended to reduce the number of children in care, and the length of time children spent in care. Those goals were partially accomplished. However, after a significant decrease, the number of children and the length of time they spent in foster care began to rise again; at the same time, there was a profound change in both the characteristics of children entering care and the foster care system itself.

The outcome of agencies' efforts to implement the reforms contained in P.L. 96-272 was that the number of children in foster care decreased from 502,000 children in 1977 to 270,000 in 1984 (Tatara 1993). Despite this initial achievement, however, the demand for foster care services began to grow once again, with steadily increasing numbers of children entering and remaining in care each year. In 1995, approximately 482,480 children were in foster care—a 79% increase in the number of children in care since 1984 (CWLA 1997). A total of 715,743 children received out-of-home car services for some period of time in 1995. This number is larger than the number of children in care, because many children enter and leave care during the year (CWLA 1997). As one commentator has noted, in 20 years, "the initial gains resulting from the new philosophy of permanency planning [as set forth in P.L. 96-272] have seemed to disappear as far as reducing the number of children in foster care." (Gershenson 1990)

How can we explain the dramatic increases in the numbers of children in foster care? We can look at four factors that have contributed to this phenomenon: an increase in the number of reports of child abuse and neglect; increasing rates of re-entry into foster care; increased time that children spend in care; and the impact of other service systems on the number of children and young people served by the foster care system.

The rise in the number of children placed in foster care is associated with the yearly increase in the **number of child abuse and neglect reports**. About 3.1 million children were reported to state authorities as abused or neglected in 1995, an increase of 49% since 1986 and 347% since 1976. Of the children in 1995 whose reports were substantiated, 54% were neglected, 25% were physically abused, and 11% were sexually abused. The remaining children suffered from emotional and other forms of maltreatment (NCPCA 1996).

BEST COPY AVAILABLE

© Child Welfare League of America 1997

Increased **re-entry rates** are also a factor in the increased numbers of children in foster care. Statistics documenting the flow of children in and out of care demonstrate this trend most clearly. Studies in Illinois and New York reveal that 20-33% of children in foster care are re-entrants (Wulczyn and Goerge 1992). In 1987, 72% of the increase in foster care placements in New York was attributable to children re-entering the system (Wulczyn and Goerge 1992). Data from New York, Illinois, Georgia, Oregon and Texas show that from 3% to 27% of children discharged to their families return to foster care (U.S. General Accounting Office 1991).

Another factor related to the growth in the numbers of children in foster care is the length of continuous **time in care**. Data on the length of time children spend in foster care are collected for children who are in care at the end of each year and children who left care during each year. Both sets of data demonstrate that throughout the 1980s, there was a decrease in the length of time children spent in care, but beginning in 1990 the average length of time children were in care again increased (Tatara 1993). The data also indicate that if children are not discharged within a short time after the initial placement in foster care, they are likely to remain in care for longer periods of time (Merkel-Holguín 1993). The effect of the increased time in care is a growing population of children who remain in the foster care system even as new children are entering care.

The growth in the number of children in foster care is also related to placements through **other systems**—the mental health and juvenile justice systems in particular. Many have pointed to the increasing use of foster care for children and young people who previously were served in mental health and correctional facilities. Between 1984 and 1990, for example, there was a 52% increase in the number of children who entered foster care after committing status and delinquent offenses (Tatara 1993). At the same time, the aggregate number of children in out-of-home care in all systems has been growing (U.S. House of Representatives 1989).

The problem, however, is far greater than the sheer numbers. The characteristics of children and of the foster care system itself have changed. Children entering and staying in care now are more apt to be characterized by emotional/behavioral problems, alcohol and other drug related difficulties, the effects of HIV/AIDS, and physical handicaps. In addition, increasing numbers of very young children are entering care, the number of adolescents in the system continues to escalate, and the foster care population is increasingly multicultural. The foster care system itself has shifted in terms of how out-of-home care is offered—the way in which family foster care is provided, the role of residential treatment care, and the growth in relative foster care.

Child welfare agencies are being confronted with increasingly complex, changing, and perplexing needs. As early as 1984, a New York study found that 40% of New York State's children in foster care manifested **emotional/behavioral problems** such as thought disorders, paranoia, suicide attempts, eating disorders, self-abuse, and attention-deficits (Ingalls et al. 1984). A similar California study in 1985 indicated that the children and youths comprising the state's foster care population presented a range of problems, which included sexual acting out and hostile behavior (Fitzharris 1985).

Substance abuse, in particular, is having a significant impact on children, young people and families, and has become an important precipitating factor in the placement of children into foster

© Child Welfare League of America 1997

BEST COPY AVAILABLE

care (North American Commission on Chemical Dependency and Child Welfare 1992). An estimated 375,000 babies are born each year exposed to drugs; approximately 5,000 infants are born each year with documented fetal alcohol syndrome; and another 35,000 infants are born with other alcohol-related birth defects (U.S. House of Representatives 1989). Fully 70% of CWLA member agencies responding to a recent survey reported that crack cocaine is a serious problem among the children and families they serve (Curtis and McCullough 1993). According to a recent GAO (1994) study, alcohol and drug abuse is a factor in the placement of more than three-quarters of the children who are currently entering foster care. In Ohio, more than two out of every five children placed in out-of-home care during 1988 came from families with parental drug problems (Governor's Office of Criminal Justice Services 1989). The trend of children being placed in foster care because of severe parental drug problems can also be seen in relatively rural states.

An estimated 7,000 children are born annually to HIV-positive mothers (CDC 1993). As the **HIV/AIDS** pandemic broadens and transmission patterns shifts from homosexual to heterosexual populations, and from men to women, another group in need of foster care is emerging—children who lose their parents to AIDS. It is projected that by the year 2000 between 72,000 and 125,000 children and youths will have lost their mothers to AIDS in the United States (Michaels and Levine 1992); other data indicate there will be 93,000-112,000 uninfected children and 32,000-38,000 children infected with HIV born to HIV-positive mothers between 1992 and 2000 (Caldwell et al. 1992). Parents with HIV will need the assistance of child welfare agencies to create permanency plans for their children, 80% of whom will not be HIV positive. In addition, increasing numbers of children who are HIV infected are already in foster care. One study conservatively estimated that in 1991 there were 1,149 HIV positive children in foster care (Cohen and Nehring 1994). With the rate of reported AIDS cases growing most rapidly among women of color and of childbearing age, it can be projected that the number of children born to HIV-infected mothers and, therefore, the number of children who will need foster care services will also escalate throughout the 1990s.

Many of the children coming into care today are **medically fragile and/or physically handicapped.** As testimony to the Budget Committee of the U.S. House of Representatives recently reflected, "the children coming into [the child welfare] system today are significantly different from the children we saw five years ago...a growing number of seriously handicapped infants at one end of the spectrum, and a preponderance of emotionally disabled teenagers at the other end" (APWA 1990). Between 1984 and 1990, there was a 12% increase in the number of children who entered foster care because of their own handicap or disability (Tatara 1993).

According to the U.S. House of Representative Select Committee on Children, Youth, and Families (1990), **infants and young children** with medical complications and physical and mental limitations constitute the fastest growing group of children in need of foster care. According to the GAO (1994), the population of young children in foster care—that is, those 36 months of age and younger—was not only much larger but also significantly different in 1991 than in 1986. The study focused on New York, California, and Pennsylvania (the states with the largest average foster care populations in 1991) and found that more young children entered foster care due to some form of parental neglect (68% in 1991 compared to 47% in 1986); their parents were more likely to abuse drugs (78% of the children in 1991 had one parent who abused drugs compared to

© Child Welfare League of America 1997

BEST COPY AVAILABLE

52% in 1986); the children had more health-related problems (58% in 1991 compared to 43% in 1986); and the children were at higher risk of ongoing developmental problems due to prenatal drug exposure (drastically increasing to 62% of the children in 1991 from 29% in 1986). A New York study of foster care trends found that in 1989, 3% of all infants in the state were placed in foster care, triple the rate of five years earlier, and children ages birth to four accounted for 31% of all first admissions to foster care in New York City (Wulczyn and Goerge 1990).

Although the proportion of **adolescents** in foster care has decreased (29.7% in 1990 from 45.3% in 1982), the number of adolescents in care has slightly increased—120,600 in 1990 compared with 118,700 young people in 1982 (Tatara 1993). Young people between 13 and 18 years of age comprise roughly one-third of the children in foster care, despite the fact that they currently comprise only about 12% of the U.S. population (Merkel-Holguín 1993). While there are no definitive explanations for this trend, some experts have pointed out that the disproportionate representation of adolescents in foster care may be related to a diversion of youth from the correctional or criminal justice systems (Hornby and Collins 1981; Timberlake and Verdieck 1987).

An especially disturbing trend in the foster care population is the increasing numbers of **children and youth of color** in care, the product largely of the worsening well-being of our nation's minority families (Stehno 1990; Tatara 1993) and rapidly changing racial/ethnic patterns. Between 1980 and 1990, there were major shifts in the general U.S. population. While the Caucasian population decreased by 3%, the African American population grew by 13%, the Native American/Alaskan Native population by 42%, the Latino population by 53%, and the Asian and Pacific Islander population by 97% (U.S. Bureau of the Census 1992). These changes are mirrored in the racial/ethnic make-up of children in the child welfare system. In 1980, 47.3% of children in foster care were children of color. By 1990, 60.7% of children in foster care were children of color (Tatara 1993).

African American, Native American and Latino children and youths continue to be disproportionately represented in the foster care system—now by a margin of more that two to one. In 1990, for the first time, there were more African American than Caucasian children in foster care. Between 1982 and 1990, the number of Latino children in care increased 172% (Tatara 1993). In 1990, African Americans represented only 12.1% of the U.S. population as a whole, but 40.4% of the foster care population; Latinos represented 9% of the U.S. population but 11.8% of the foster care population; and Native Americans and Asian or Pacific Islanders represented 3.7% of the total U.S. population, but 4.3% of the foster care population (U.S. Bureau of the Census 1992; Tatara 1993). The authors of a 1989 study of foster care trends found that the dramatic increase in the number of children in foster care in Illinois between 1987 and 1988 was due entirely to African American children entering care in numbers disproportionate to their membership in the general population (Wulczyn and Goerge 1990).

A number of studies also indicate that children of color receive differential treatment in the foster care system. African American children are less likely to have service plans and less likely to have regular contact with their families (Olson 1982). Similarly, Latino children are less likely to have plans for regular parental contact than Caucasian children in foster care (Shyne and Schroeder

© Child Welfare League of America 1997

BEST COPY AVAILABLE

1978). Not surprisingly, African American children remain in foster care longer and receive less desirable placements than majority race children (Stehno 1990; Close 1983).

In addition to the changing characteristics of children in care, the way in which foster care is provided has also undergone change. It is estimated that about three-fourths of the children living in out-of-home care now reside in **family foster homes**. Approximately one-fourth reside in group residential settings (CWLA 1997). Increasingly, children are needing specialized **treatment services**, either through specialized or treatment foster care or through group or residential care and demands are being made on child welfare systems to develop therapeutic or treatment foster care resources to respond to the complex needs of growing numbers of children entering care. At the same time, more young people are requiring specialized residential treatment. In 1990, there were approximately 66,600 children in group homes or residential care settings, a number which has slightly increased over time (Tatara 1993). As the number of inpatient psychiatric placements available to children has decreased, treatment foster care and residential and group care have been asked to meet the needs of a more diverse and emotionally disturbed population. Many of these young people have experienced repeated disruptions in foster care and arrive at these specialized treatment settings with severe problems. Other young people, particularly those served by child welfare residential care, are juvenile offenders or others with serious conduct disorders or prior court contact who previously were served by other systems.

The dramatic growth in **kinship care or relative foster care** also has changed the nature of foster care. It is estimated that approximately one-fourth of the 482,480 children in foster care now live with kin. The increasing number of children needing out-of-home care and the declining number of foster families have prompted a recognition of relative foster care as an essential option in the array of child welfare services. Increasingly, the child welfare field is seeking kin as the first option for children who must be separated from their parents (CWLA 1997).

Historical Roots: How We Got Where We Are

Although the current status of foster care is also largely a product of broader social forces—including poverty, homelessness, substance abuse, HIV/AIDS, and adolescent pregnancy and parenting—the welfare of children and families has always been affected by broader economic and political realities. Examples from history clearly illustrate this connection. In 1933, the U.S. Children's Bureau, in collaboration with CWLA, convened a Conference on Present Emergencies in the Care of Dependent and Neglected Children. The conference report noted that "the welfare of destitute and neglected children has been seriously affected by several factors arising from the depression, including: reduction in state and local expenditures in many areas for the support of needy children in public and private agencies, and a lack of employment for needy children reaching the age of 16 or 17 years. Many children are suffering and the welfare of many more is seriously endangered" (Bremner 1974: 613). Nearly 40 years later, another commission noted that "meager public assistance, coupled with the paucity of day care, homemaker services, and accessible medical services, make it hardly surprising that the one-parent family of low socioeconomic status is the most vulnerable to neglect and subsequent child placement" (Bremner 1974: 675).

© Child Welfare League of America 1997

Poverty has always seriously undermined the well-being of children and families. Almost 22% of America's children—14.6 million—were living in poverty in 1992 (U.S. Bureau of the Census 1993), despite the fact that the United States remains one of the richest countries in the world. The percentage of Latino children living below the poverty level is approximately 40%; for African American children, the percentage climbs to almost 47%. This compares to a poverty rate of 17% for Caucasian children. Poverty is often tied to single-parent status. Almost 25% of all children in the U.S. lived in one-parent families in 1990, compared with 9% in 1960. The percentages are even higher for children of color (U.S. House of Representatives 1994). Fully half of the children born in 1990 will spend part of their childhood with only one parent; that parent is likely to face a continuing struggle with the economic and emotional burden of unshared parenting. Poverty, often associated with underemployment and unemployment, leaves families unable to afford even such basic necessities as food, clothing, and shelter and other essentials such as medical care and transportation.

Homelessness is also impacting vulnerable families. At least 100,000 youngsters sleep each night without a home (Institute of Medicine 1988). Families with children represented 43% of the homeless population in 1992 (U.S. Conference of Mayors 1993). Homelessness continues to be a factor in the separation of children and parents, as well as a cause for delays in family reunification once children enter foster care. In 1988, for example, homelessness was a factor in over 40% of placements into foster care in New Jersey, and the sole precipitating cause in 18% (Ooms 1990).

As previously discussed, **alcohol and other drug abuse** significantly affect the child welfare system and foster care. The effects of parental substance abuse include prenatal drug exposure as well as environmental exposure to parental alcohol and drug abuse. Young children entering foster care often suffer the physical, emotional and developmental effects of parental drug and alcohol abuse.

As with alcohol and other drug abuse, the **HIV/AIDS epidemic**, described earlier, is also affecting the child welfare system. The permanency planning needs of children who lose their parents to AIDS, the demands for children and young people in care who are HIV positive, and the HIV/AIDS prevention education needs of young people in foster care are greatly impacting the child welfare service delivery system.

Finally, **adolescent pregnancy and parenting** have had an impact on foster care. Every 31 seconds, an adolescent becomes pregnant, and every minute an adolescent gives birth (CDF 1994). In 1991, the latest year for which there is data, there were 531,591 births to teen mothers in the United States, with 12,014 of the births to girls under age 15. The United States has an escalating adolescent birth rate of 62 births per thousand (U.S. Department of Health and Human Services 1993), a rate higher than all other industrialized countries. Adolescent mothers have a higher than average chance of suffering pregnancy complications, including premature delivery; they are less likely to obtain prenatal care; they are less likely to ever complete high school than their nonparenting peers; and they will earn about half the lifetime income of women who first give birth in their 20s. Teenage fathers also face certain disadvantages—they tend to have lower incomes, less education, and more children than men who postpone having children until their 20s (Alan Guttmacher Institute 1994). The social and economic problems that teen parents are likely to face place them and their children at risk. To an increasing extent, children entering foster care

© Child Welfare League of America 1997

are the children of young parents who themselves have experienced abuse and neglect (CWLA 1994a).

Issues for Foster Care Today

Given the recent events and historic forces that have resulted in the foster care system we have today, there are a number of critical issues the system must address. These issues include the needs of children in care, particularly their health, mental health, developmental, and educational needs; the needs of the biological families with whom the system is working; the need for adequate numbers of qualified foster parents; and the need for highly skilled staff.

Children in foster care exhibit much higher rates of **physical, emotional, and developmental problems** than children of the same age who are not in care. Many children and youth come from chronically poor families. That poverty, particularly when combined with the effects of abuse and neglect, places youngsters at high risk for health, mental health, and developmental problems (Halfon and Klee 1991). Physically, children in foster care are likely to suffer from a range of acute and chronic health problems (Wald et al. 1985). A 1984 study, for example, found that children in care experience upper respiratory infections, dermatologic disorders, dental caries and malnutrition in significant numbers (New York State Department of Health and Human Services 1990). Studies of children in foster care in New York City, Chicago, Baltimore and Canada indicate that children in care, when compared to children who are not in care, have higher rates of vision, hearing, growth, and dental problems (Moffatt et al. 1985; Swire and Kavaler 1977; White et al. 1987).

Children and young people in care are also likely to suffer from a range of psychological and developmental problems that can lead to significant behavioral and emotional difficulties. One study indicates that the incidence of emotional, behavioral and developmental problems among children in foster care (including depression, conduct disorders, difficulties in school, and impaired social relationships) is three to six times greater than the incidence among other children (Dubowitz 1990). Parental substance abuse and HIV infection further complicate the health and developmental status of many children in care.

While children often come into care with enormous health, mental health and developmental needs, in many instances the foster care system itself exacerbates those problems. As children move from one setting to another, their already compromised physical and mental health may further deteriorate. One study, for example, found a direct relationship between the number of placements children experienced and the level of hostility they displayed (Fanshel et al. 1989). Results of another study indicate that children who experience multiple placements tend to have higher levels of behavioral and emotional problems, longer stays in foster care, and difficulties in returning home or making the transition to adoption (Office of the Florida Auditor General 1989).

As with health, mental health, and developmental needs, the **educational needs** of children in care can be substantial, and, again, the foster care system can exacerbate the problems. Various studies have indicated that children and young people in foster care tend to have limited education and job skills (Barth, 1990); perform more poorly educationally than children who are not in foster care (Ohio Department of Human Services 1987), lag behind in their education by at least

© Child Welfare League of America 1997

BEST COPY AVAILABLE

one year (Jones and Moses 1984), and have lower educational attainment than the general population (Festinger 1983; Cook and Ansell 1986). Multiple placements, placements outside children's communities and away from their own school's district, and lack of continuity in educational services exacerbate existing education problems.

Vocational services for children in foster care are also sorely lacking. Fewer than 25% of CWLA member agencies that responded to a survey on independent living services indicated that they provide employment-related services for young people in care; 17% provide employment and career planning assessments; 16%, job search training; and 24%, vocational training (DeWoody et al. 1993). It is not surprising, therefore, that young people in foster care find it more difficult to obtain employment than youths in general. One longitudinal study found that only 49% of the young people discharged from foster care were employed, compared to a national employment level for young people 16 to 24 years of 65% (Westat 1991).

Biological families of children in foster care have multiple and complex needs as well. As outlined above, families of children in foster care are more likely to be poor. The problems their children exhibit, such as emotional difficulties, acute and chronic health problems, chemical dependency, and homelessness, are also problems that the families must contend with as they seek to improve their lives and those of their children. Families of children in foster care need many of the same things that their children do—a safe environment, someone to care about them, help with communication and problem-solving, and daily living skills. They often need assistance with concrete services, such as transportation, housing, child care, health care, and employment.

Like their children in foster care, families also need to feel in control of their lives. Like foster parents, they need a number of supports and services, such as emergency and respite care, help with parenting and behavior management. They need to feel that their opinions and experience are valued. Often, the system fails to involve parents or communicate a belief that parents play a vital role in their child's foster care experience. In addition, the system often does not provide the supports and services families need to help them make necessary changes, strengthen the parent-child relationship, and ease the transition when children are returning home. These forms of assistance are critical if reunification and other permanent options for children are to be achieved

As the needs of children, young people and their families have escalated, **foster parents** and foster care resources have become increasingly in short supply in much of the country, especially in the large cities (Kamerman and Kahn 1989). The number of foster homes decreased from 147,000 in 1984 to approximately 141,000 in 1995 (CWLA 1997). A number of factors account for the dwindling supply of foster parents. Current foster parents age and retire from the system while others drop out because they are dissatisfied with the child welfare system. Social and economic changes in our society, particularly the increase in single parent families and the movement of women out of the home and into the paid labor force, also have shrunk the pool of potential foster parents. At the same time, the demands on foster families have changed. Foster parents increasingly are asked to care for children with very complex and special medical, developmental, and behavioral needs (National Commission on Family Foster Care 1991).

The recruitment and retention of foster parents have become critical issues for the foster care system. Economic factors have contributed significantly to recruitment and retention difficulties

© Child Welfare League of America 1997

BEST COPY AVAILABLE

In 1995, the average monthly foster care reimbursement rate was only $344 for children age two, $362 for children age nine, and $410 for youths age 16 (APWA 1996). This represents an 8% increase in the average reimbursement to foster parents since 1991. Studies indicate that foster parents, especially single, older, or foster mothers of color, have incomes lower than many other American families (Westat 1981; Fein et al. 1990). Historically, foster parents have been reimbursed at very low rates for the care they provide, and they have been expected to subsidize the child welfare system through their time and out-of-pocket expenses for services such as child care.

In addition to economic factors, internal systems issues have impacted the retention of foster parents. Surveys of foster parents repeatedly find that the primary reason foster parents leave service with public child welfare programs is the lack of agency responsiveness, communication, and support. According to the National Commission on Family Foster Care (1991), as many as 60% of foster parents withdraw from the program within the first 12 months. Lack of responsiveness and support for foster parents plays out in a number of ways:

- Foster parents often do not receive sufficient emergency, weekend, or vacation respite from their round-the-clock responsibilities.

- Foster parents often do not receive consultation and support from skilled social workers nor immediate responses to crisis situations.

- The role of the foster parent as a partner and team member is often ignored, resulting in role confusion and frustration.

- Foster parents often have difficulty in obtaining liability protection while caring for children who, because of emotional difficulties, may damage their homes and personal property or that of others.

- Foster parents generally receive inadequate training. While foster parents are usually required to attend a specified number of hours of training per year, there is often little systematic or participatory planning regarding the content and process of the training.

Recruitment and retention of foster parents of color, in particular, are of great concern because of the increasing numbers of children of color entering foster care and the importance of reducing the trauma to the child by making same race placements at the point of entry into the system. Foster parents have consistently been shown to be the most effective recruiters of new foster parents, especially culturally and racially diverse foster parents. Foster parents' attitudes about the agency with which they are affiliated—perspectives shaped to a great extent by agency responsiveness and communication with and support of foster parents—significantly impact the retention of existing foster parents and the recruitment of new foster parents.

Last, there are issues around child welfare agencies' needs for adequate numbers of qualified staff. Most agencies currently face increasing foster care caseloads coupled with staff reductions and decreases in staff supports such as training. Even without staff reductions, rising demands for

© Child Welfare League of America 1997

BEST COPY AVAILABLE

out-of-home care services have caused caseloads to expand, making staff workloads unmanageable and morale low. On average, public agencies report a staff turnover rate of 6% and private agencies report a staff turnover rate of 23% (CWLA 1996). Under such conditions, it often is impossible for a social worker to have frequent and consistent contact with parents and children, thus making it even more difficult to establish the relationships necessary to develop and implement effective permanency plans.

Staff qualifications including education and experience impact the system's ability to provide quality services that result in permanency for children. Studies report that only 25-27% of child welfare caseworkers providing direct services have any social work training, and of these, only 9-10% have graduate degrees in social work. Only 50% of caseworkers have experience in working with children and families or in any human service field. Low salaries contribute to the difficulties in attracting experienced and professionally trained staff. In 1995 letter carriers earned more than child welfare supervisors and social workers with M.S.W. degrees (CWLA 1996). The low salaries are related to a variety of factors, including agency declassification of caseworker positions and deletion of requirements for professional social work education. There is growing recognition that collaboration must be enhanced among the schools of social work, public agencies, and the federal government to reprofessionalize public child welfare staff.

In addition to professional preparation, ongoing staff training is essential. Although there has been a proliferation of training programs over the past decade, many training programs do not transmit the knowledge and skills that all levels of child welfare staff and foster parents need to have in order to deliver effective and efficient foster care services. Competency-based training programs for workers, supervisors, administrators, and foster parents are needed to ensure the delivery of family-centered, culturally sensitive and community-based services.

Foster Care Reconceptualized

In keeping with the changes detailed above and the new opportunities afforded by the family preservation and support legislation, the child welfare system faces a major challenge: reconceptualizing foster care. A reconceptualized foster care system will reaffirm the goals of P.L. 96-272 within a broader, family-centered context. Almost 17 years after the landmark child welfare legislation, there is an added dimension to child welfare work. While keeping children with their families and reunifying children and families continue to be our primary goals, there is a broader recognition that families come in a variety of forms, that our work must be guided by a thorough assessment of the family, and that our interventions must engage the whole family in order to be successful. For those children who cannot stay at home or return to their families, we must work toward other permanent family-centered outcomes such as adoption, which will provide permanent families for children.

As the process of reconceptualizing foster care is undertaken, we need to capitalize on new knowledge coming out of reform efforts already underway in many states to redesign foster care as a meaningful component of the newly emerging child welfare system that supports family preservation and support, as well as permanency planning. In approaching and outlining strategies to accomplish this task, it is important to understand the context of the current crisis in the broad child welfare system, and within that broad system, to understand, the current crisis in

© Child Welfare League of America 1997

BEST COPY AVAILABLE

foster care, the nature and characteristics of the newly emerging child welfare system, the implications of this emerging system for foster care and for permanent homes for children, and how recent legislation supports implementation of the reconceptualized system. In addition, it is important to identify the primary themes that underlie a reconceptualized foster care system as they provide a framework for specific strategies.

The current **crisis in child welfare** is not newly arrived. Its origins lie in at least three national trends that have been apparent for some time. The first is a wholly desirable heightening of societal expectations and standards for acceptable family functioning. Since the 1960s, states have steadily broadened the definition of child abuse and neglect and clarified and expanded the mandates for reporting suspected child maltreatment. At the same time, there has been increased public sensitivity to the symptoms and signs of child endangerment. The second contributor to the crisis is the growing number of families who by virtue of poverty, discrimination, family structure, and other factors, are at increased risk of child abuse and neglect. A number of factors, as previously discussed, have converged to undermine the resilience and coping capacity of families: poverty, unemployment, homelessness, substance abuse, and HIV/AIDS, as well as declining informal and extended family supports. The third contributor lies in the overall failure of public child welfare policy and practice to respond to the fundamental economic and societal changes that have overwhelmed increasing numbers of families. Public policy has tended to confine the state's authority to intervene on behalf of children to those circumstances in which a family has demonstrably failed to meet accepted social standards for parental performance. Those standards, however, gradually have increased to demand more in terms of parental performance, while at the same time, the functional capacity of many families has declined. The result has been an inevitable demand on a still largely reactive and remedial child welfare system, a demand which has steadily exceeded the system's capacity to keep pace. Without a basic reorientation in public policy and agency practice, the current cultural, economic, and demographic trends appear certain to prolong this child welfare crisis indefinitely into the future.

The crisis in child welfare has been played out in a number of ways in agency policy and practice, with harmful results for the children and families the system was designed to serve. These effects are evident throughout the system—ranging from the way in which agencies respond to reports of child abuse and neglect to the way in which foster care services are designed and delivered and permanency planning is implemented. The public child welfare system currently is overwhelmed by the dramatic increase in the occurrence, recognition, and reporting of child abuse and neglect, and intrafamily conflict. Too often, triaging is the way agencies cope with this increase, and too often, triaging results in nonresponse. When the system does respond, the assessment of risk is too often hasty and incomplete, and in some cases, tragically mistaken. The mistakes range from inadequate recognition of real danger to unwarranted intrusion. Equally alarming is the deteriorating quality of the responses to substantiated cases of child abuse and neglect. In those cases when placement in foster care is not recommended, the extent of intervention frequently has declined to unsystematic referrals, sporadic monitoring, and unwarranted hope that all will be well. Family support and ongoing services to ensure family stability and child safety may rarely be available.

The nation's **foster care system,** as part of the larger child welfare system, is likewise in **crisis**. To a growing extent, placement in care is the system's response. The increasing admissions to foster care services, however, are outstripping the availability of appropriate out-of-home care

© Child Welfare League of America 1997

resources. Overcrowding of group care facilities, assignment of children to unnecessarily restrictive placements in light of their needs, and the temporary (and sometimes prolonged) warehousing of youngsters in shelters as they await placement, are symptomatic of the current crisis. Foster care also has been caught up in the debate that pits those in favor of "protecting children" against those invested in "preserving families." For some, foster care is seen as antithetical to preserving families and, therefore, a "bad" service choice for all children; for others, foster care is viewed as a necessary and preferred vehicle for protecting children from maltreating "bad" families. In the face of this debate, the value and role of foster care has become the subject of controversy, with questions raised about the part that foster care plays and should play within the broader child welfare system.

Simultaneously with this crisis, however, the **child welfare system is experiencing the beginning of a reconceptualization.** It appears to be on the verge of a major paradigm shift. Our faith in our current ways of caring for children and, particularly, children and families who are experiencing difficulties, is wavering. Traditional service approaches, which have defined child welfare practice for several decades, clearly do not stand up to the demands generated by the current crisis. Consensus is growing that a new paradigm, a new way of thinking about and doing business, is needed if we are to achieve the goals of health, well-being and safety for children and families.

The thinking that has emerged over the last decade has been called "family-centered," "family-focused," and "family-based." In essence, it is an approach which focuses on the needs and welfare of children within the context of their families and their communities. It views the family as central to the child's well-being and seeks family-based outcomes for all children and young people. This approach was prompted by the work of Maas, Freud and Solnit, Fanshel, and others, who collectively brought attention to children's needs for permanence and for family and the potentially negative impacts of unplanned placement on children; and the work of Pike and Emlen who demonstrated that the child welfare system can work with families toward reunification while achieving other permanent family options for children who cannot return home. Much work has been done in developing relevant theoretical and practice frameworks, such as ecological and systems theory, cognitive and behavioral theory, and a variety of family therapy modalities. These frameworks have informed the work of such practitioners as Bryce and Lloyd, Kinney and Haapala, Showell and Allen and others, as they have pioneered approaches to working with families—approaches that are at the heart of family-centered practice.

The shift to families and communities as the locus of child welfare services parallels shifts that are occurring in other fields, such as mental health and developmental disabilities, as well as the trends in our broader society. It is a shift toward a more participatory and horizontal approach in the workplace and in service delivery, one that begins by listening to the client (the family), focuses on self-sufficiency as well as caregiving, is centered in the home and community, values and embraces diversity, and is nonhierarchical in its approach to information sharing and problem solving. At its core, family-centered practice recognizes the strength of family relationships and builds on those strengths to achieve optimal outcomes for children and families.

One particularly significant development that has supported this shift in emphasis to families and communities is **the Family Preservation and Family Support Program (P.L.103-66)**, the first

© Child Welfare League of America 1997

BEST COPY AVAILABLE

major federal legislation addressing children since P.L. 96-272. Importantly, it translates current family-centered theory and practice into public policy and requires states to engage in a comprehensive planning process for the development of a "meaningful and responsive family support and family preservation strategy" (HHS Program Instruction Highlights, January 1994).

In conjunction with the theory and practice trends already being implemented, The Family Preservation and Family Support Program provides an important opportunity to implement a **reconceptualized foster care system** based upon our new recognition of children's connections to and embeddedness in their families and their communities. This new understanding can be expressed in five broad themes: the importance of family to children; children's lifelong connections to their families; the uniqueness of families; the shifting availability of family members; and the need to broadly define family or family-like support.

Families are always important to children. Because families represent the most basic and important social unit in American society, it is essential that children have every opportunity to grow and develop within their families of origin whenever possible or with another family through adoption when their own families cannot provide the ongoing care and support that will assure their safety. Stability in living arrangements and continuity and security in the parent-child relationship are essential. All children need a stable and continuous relationship with a nurturing person or persons in order to develop physically, socially, emotionally, intellectually, and morally.

No matter how chaotic or troubled, families are always central to positive outcomes for children. Regardless of our initial diagnosis and regardless of the intervention, most children and youths return to their families. For example, in 1990, 67% of children and youths in out-of-home care were reunified with their families or placed with a relative or other caretaker following placement compared to a rate of 50% in 1982; this represents a 57% increase in the number of children who returned home since 1984 (Tatara 1993). Clinicians estimate that 90% of those who enter foster care and do not immediately return home, ultimately will return home; and as many as 60% of youth who are being prepared to live independently, upon discharge, return to live with their families (DeWoody et al. 1993).

Given the reality of out-of-home care, a reconceptualized foster care system must have as a primary goal the preparation of children, youths, and their families to live together more successfully. The system should be oriented toward assuring that out-of-home placements are not undertaken until all reasonable efforts to preserve families have been thoroughly explored. Placement of children into foster care must occur only when the safety or well-being of the child is jeopardized and services to the family cannot remove this jeopardy. Foster care must be seen as a temporary service, oriented toward reunifying the family as quickly as is safe for the child or implementing other permanency options promptly if reunification is not possible.

Children need a life-long connection to family. Even for children who cannot physically return home—even for those from the most troubled families—their sense of self, ability to cope with and resolve loss, and ability to form new and more lasting attachments are strengthened if they have had an opportunity to work through family issues (Fahlberg 1991; Jewett 1982), particularly when they can work through these issues directly with their family members. Practice has not always honored this theme. Sometimes, we have sought to shield children from additional

© Child Welfare League of America 1997

BEST COPY AVAILABLE

rejection or further emotional trauma by distancing them from their biological families. Or we have tried to protect foster parents, other care providers, or ourselves from the disruption that may accompany family involvement. Too often, we cite family members' seeming lack of interest or participation in the life of the child as a reason for not supporting family involvement rather than as an indicator that we must find different ways of understanding and engaging families. Never by ignoring families do we make families go away; they are always there in the minds and hearts of the children.

The theme of children's lifelong connection to family means that in a reconceptualized foster care system, agencies and social workers must have the commitment, capacity, and courage to fully involve families and, with family involvement, to actively pursue reunification or other permanent family solutions for children.

Families and family members are unique. Child welfare service providers must take into account the individual developmental needs of the child, the child's family of origin, and the foster family, including the physical, psychological, and social needs of each. Children and families deal with different developmental issues at different stages of family life, and these must be recognized, understood, and addressed. In addition to developmental needs, family uniqueness is also expressed in culture. Foster care, consequently, must be truly community-based and culturally responsive to the characteristics of the children and families within the community. By implication, children should be placed with families within their own cultural groups, neighborhoods, and communities whenever possible.

To adequately meet the unique and individualized needs of families, foster care should be based on a team approach that includes the foster family, the child's social worker(s), the child's family of origin, and the child, all of whom should actively participate in the development and implementation of the permanency plan. The team also should reflect the integration of foster care with other child welfare services and other service systems. Child welfare should work in collaboration with the juvenile justice, mental health, developmental disabilities, education, public health, substance abuse and medical assistance systems to assure that the needs of children and families are met regardless of where they first encounter the public system of services.

As **families change over time, so does the availability of various family members** as resources to the child. We are often surprised when we reach out to families, including those who are listed in the case record as "not available," to learn that a parent or other family member really does want to be a resource for a child. We also are surprised when parents who initially seemed resistant and hostile are the first to "get their lives together" because we stayed with them long enough that they could feel supported. The reality that families and the individuals within those families can and do change calls for a reconceptualized foster care system that has the capacity to more fully understand families from the beginning of the system's involvement with them, including an understanding of their strengths; appreciation of the dynamic nature of families, and subscription to the belief that family members can change.

A **broadened definition of family or family-like support** and renewed valuing of all those who can contribute to a child and his/her family's well being directs us to look to a variety of individuals and institutions to help families and children and define "helping" in more inclusive and

© Child Welfare League of America 1997

BEST COPY AVAILABLE

less conventional ways. The family preservation and support movements, as well as successful self-help efforts in communities across the country, have taught us that formal modes of helping such as "counseling," "therapy," and "treatment," are of limited value unless they are preceded by or accompanied by other kinds of help and provided by a variety of helpers. For example, a church-sponsored parent support group may be the greatest source of help for a parent whose child has returned home from foster care.

The message for a reconceptualized foster care system is that we need to find ways to recognize and build on the strengths of a wide array of potential helpers, including informal care providers, foster parents, and parents and to make optimal use of all potential resources, especially those in the child's family and community.

The **Family Preservation and Family Support Program** provides an excellent vehicle for beginning to reconceptualize foster care in light of these themes. First, it defines families broadly, including adoptive, foster, and extended families in addition to biological families. It recognizes the importance of supporting and strengthening families when children are in foster care or with relatives and when they have become part of a new family through adoption or guardianship. It recognizes the diverse family options that must be available to children and their families. Second, the legislation supports the reconceptualization of foster care in its definitions of family preservation and family support services. In defining family preservation services, the legislation specifically refers to "service programs designed to help children...return to families from which they have been removed; or ...be placed for adoption, with a legal guardian, or...in some other planned living arrangement." Family support services are defined as "services to promote the well-being of children and families...(and) to increase the strength and stability of families (including adoptive, foster, and extended families)." The legislation is designed to support and strengthen families for children "in the system" as well as those who have not yet entered the system, and to build our capacity to work with families whose children are in out-of-home care in order to return children home or achieve other lasting family connections for them.

The themes that underlie the reconceptualization of foster care—families are important, children have lifelong connections to family, families and family members are unique, families change over time, and family must be broadly defined—are fundamental to the realization of a family-focused foster care service system. They provide the substantive framework for moving forward. Equally important is how we go about changing the system in a way that honors the spirit of the principles as well as the specific content of each.

BEST COPY AVAILABLE

© Child Welfare League of America 1997

References

Alan Guttmacher Institute. (1994). *Sex and America's Teenager*. New York: Author.

American Public Welfare Association (APWA). (1990). *A Commitment to Change*. [Report of the National Commission on Child Welfare and Family Preservation]. Washington, D.C.: American Public Welfare Association.

American Public Welfare Association. (1996). "Foster Care Rates." *W-Memo*, 6(2), 23-24.

Barth, R. (1990). "On Their Own: The Experiences of Youth After Foster Care." *Child and Adolescent Social Work*, 7(5), 419-40.

Bremner, R. (1974). *Children and Youth in America, Volume III, 1933-1973, Parts 1-4*. Boston: Harvard University Press.

Caldwell, M., P. Fleming, and M. Oxtoby. (1992). "Estimated Number of AIDS Orphans in the United States." *Pediatrics*, 90(3), 482.

Centers for Disease Control and Prevention. (1993). *HIV/AIDS Surveillance Report: Third Quarter Edition*. Atlanta, GA: CDCP.

Children's Defense Fund. (1994). *State of America's Children Yearbook 1994*. Washington, D.C.: CDF.

Child Welfare League of America. (1994a). *Welfare Reform and the Minor Mothers' Residency Requirement*. Washington, D.C.: CWLA.

Child Welfare League of America. (1994b). *Kinship Care: A Natural Bridge*. Washington, D.C.: CWLA.

Child Welfare League of America. (1996). *1995 Salary Study*. Washington, D.C.: CWLA.

Child Welfare League of America. (1997, publication pending). *Child Abuse and Neglect: A Look at the States*. Washington, D.C.: CWLA.

Close, M. (1983). "Child Welfare and People of Color: Denial of Equal Access." *Social Work Research and Abstracts*, 19(4), 13-20.

Cohen, F. and W. Nehring. (1994). "Foster Care of HIV-positive Children in the United States." *Public Health Reports*, 109(1), 60-67.

Cook, R. and D. Ansell. (1986). *Study of Independent Living Services for Youth in Substitute Care*. Rockville, MD: Westat, Inc.

© Child Welfare League of America 1997

Curtis, P. and C. McCullough. (1993). "Impact of Alcohol and Other Drugs on the Child Welfare System." *Child Welfare*, 72(6), 533-42.

DeWoody, M., K. Ceja, and M. Sylvester. (1993). *Independent Living Services for Youths in Out-of-Home Care*. Washington, D.C.: Child Welfare League of America.

Dubowitz, H. (1990). *The Physical and Mental Health and Educational Status of Children Placed with Relatives: Final Report*. Baltimore, MD: Department of Pediatrics, School of Medicine, University of Maryland.

Fahlberg, V. (1991). *A Child's Journey Through Placement*. Indianapolis, IN: Perspectives Press.

Fein, E., M. Kluger, and A. Maluccio. (1990). *No More Partings: An Examination of Long-term Foster Family Care*. Washington, D.C.: Child Welfare League of America.

Festinger, T. (1983). *No One Ever Asked Us*. New York: Columbia University.

Fitzharris, T. (1984). *The Foster Children of California*. Sacramento, CA: The Children's Services Foundation.

Gershenson, C. (1990). *Preparing for the Future Backwards: Characteristics of the Ecology for Children and Youth in Long-term Out-of-Home Care*. Paper presented at The Casey Family Program Symposium on Children and Youth In Long-Term Out-of-Home Care, Seattle, WA.

Governor's Office of Criminal Justice Services. (1989). *Understanding the Enemy: An Informational Overview of Substance Abuse in Ohio*. Columbus, OH: GOCJS.

Halfon, N. and L. Klee. (1991). "Health and Development Services for Children with Multiple Needs: The Child in Foster Care. *Yale Law and Policy Review*, 9(1), 71-96.

Hornby, H. and M. Collins. (1981). "Teenagers in Foster Care: The Forgotten Majority." *Children and Youth Services Review*, 3, (1/2), 7-20.

Ingalls, R., R. Hatch, and F. Meservey. (1984). *Characteristics of Children in Out-of-Home Care*. Albany, NY: The New York State Council on Children and Families.

Institute of Medicine, Committee on Health Care for Homeless People. (1988). *Homelessness, Health and Human Needs*. Washington, D.C.: National Academy of Sciences.

Jewett, C. (1982). *Helping Children Cope with Separation and Loss*. Harvard, MA: Harvard Common Press.

Jones, M. and B. Moses. (1984). *West Virginia's Former Foster Children: Their Experience and Their Lives as Young Adults*. New York: Child Welfare League of America.

© Child Welfare League of America 1997

Kamerman, S. and A. Kahn. (1989). *Social Services for Children, Youths, and Families in the U.S.*. New York: The Annie E. Casey Family Program.

Lieberman, A., H. Hornby, and M. Russell. (1988). "Analyzing the Educational Backgrounds and Work Experiences of Child Welfare Personnel: A National Study. *Social Work*, 33 (6), 485-89.

Merkel-Holguin, L. (1993). *The Child Welfare Stat Book 1993*. Washington, D.C.: Child Welfare League of America.

Moffatt, M., M. Peddie, J. Stulginskas, I. Pless, and N. Steinmetz. (1985). "Health Care Delivery to Foster Children: A Study." *Health and Social Work*, 10(2), 129-37.

Michaels, D. and C. Levine. (1992). "Estimates of the Number of Motherless Children and Youth Orphaned by AIDS in the United States." *Journal of the American Medical Association*, 268, 3456-61.

National Commission on Family Foster Care. (1991). *A Blueprint for Fostering Infants, Children and Youths in the 1990s*. Washington, D.C.: Child Welfare League of America.

National Committee to Prevent Child Abuse (NCPCA). (1996, April). *Current Trends in Child Abuse Fatalities: The Results of the 1995 Annual 50 State Survey (Revised)*. Chicago, IL: NCPCA.

New York State Department of Health and Social Services. (1990). *Health Supervision of Children in Foster Care*. The Consensus Conference.

North American Commission on Chemical Dependency and Child Welfare. (1992). *Children at the Front: A Different View of the War on Alcohol and Drugs*. Washington, D.C.: Child Welfare League of America.

Office of the Auditor General, State of Florida. (1989). *Performance Audit of the Foster Care Program*. Tallahassee: OAG.

Ohio Department of Human Services. (1987). *Children in Out-of-Home Care*. Columbus, OH Division of Children and Family Services.

Olson, L. (1982). Predicting the permanency status of children in foster care. *Social Work Research and Abstracts*, 18, 9-20.

Ooms, T. (1990). *The Crisis in Foster Care: New Directions for the 1990s*. [Background briefing report and meeting highlights]. Washington, D.C.: Family Impact Seminars.

Schor, E., R. Aptekar, and T. Scannell. (1987) *The Health Care of Children in Out-of-Home Care*. Washington, D.C.: Child Welfare League of America.

© Child Welfare League of America 1997

BEST COPY AVAILABLE

Shyne, A. and A. Schroeder. (1978). *National Study of Social Services to Children and Their Families* (DHEW Publication No. 78-30150). Washington, D.C.: Department of Health and Human Services, U.S. Children's Bureau.

Stehno, S. (1990). "The Elusive Continuum of Child Welfare Services: Implications for Minority Children and Youth. *Child Welfare*, 69(6), 551-562.

Siu, S and P. Hogan. (1989). "Public Child Welfare: The Need for Clinical Social Work. *Social Work*, 34(5), 423-30.

Swire, M. & F. Kavaler. (1977). "The Health Status of Foster Children." *Child Welfare*, 56(10), 635-53.

Tatara, T. (1993). *Characteristics of Children in Substitute and Adoptive Care: A Statistical Summary of the VCIS National Child Welfare Data Base*. Washington, DC: American Public Welfare Association.

Timberlake, E. and M. Verdieck. (1987). "Psychosocial Functioning of Adolescents in Foster Care. *Social Casework*, 68(4), 214-22.

U.S. Bureau of the Census. (1993). *Poverty in the United States: 1992*. Current Population Report, Series P60-185. Washington, D.C.: U.S. Government Printing Office.

U.S. Bureau of the Census. (1992). *Statistical abstract of the United States, 1992*, 112th Edition Washington, D.C.: U.S. Government Printing Office.

U.S. Conference of Mayors. (1993). *A Status Report on Hunger and Homelessness in America's Cities: 1992*. Washington, D.C.: U.S. Conference of Mayors.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect (NCANDS). (1994). *Child Maltreatment 1992: Reports from the States to the National Center on Child Abuse and Neglect*. Washington, D.C.: U.S. Government Printing Office

U.S. Department of Health and Human Services. (1994). *Program Instruction Highlights: Family Preservation and Family Support*.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. National Center for Health Statistics. (1993). "Advance Report of Final Natality Statistics 1991." *Monthly Vital Statistics Report*, 42(3): 1+.

U.S. General Accounting Office. (1994). *Foster Care: Parental Drug Abuse has Alarming Impacts on Young Children*. Report to the House of Representatives, Committee on Ways and Means, GAO/HEHS-94-89. Washington, D.C.: U.S. Government Printing Office.

© Child Welfare League of America 1997

BEST COPY AVAILABLE

U.S. General Accounting Office. (1991). *Foster Care: Children's Experiences Linked to Various Factors: Better Data Needed.* Report to the U.S. Senate, Committee on Finance, GAO/HRD-91-64. Washington, D.C.: U.S. Government Printing Office.

U.S. House of Representatives, Committee on Ways and Means. (1994). *1994 Green Book, Overview of Entitlement Programs.* Washington, D.C.: U.S. Government Printing Office.

U.S. House of Representatives, Select Committee on Children, Youth and Families. (1989). *No Place to Call Home: Discarded Children in America.* Washington, D.C.: U.S. Government Printing Office.

Wald, M., J. Carlsmith, and P. Liederman. (1985). *Protecting Abused/Neglected Children: A Comparison of Home and Foster Placement.* Palo Alto, CA: Stanford Center for the Study of Youth Development.

Westat, Inc. (1991). *A National Evaluation of Title IV-E Foster Care Independent Living Programs for Youth*, Phase 2, Final Report. Rockville, MD: Westat, Inc.

White, R., M. Benedict, and S. Jaffe. (1987). "Foster Child Health Care Supervision." *Child Welfare*, 66(5), 387-98.

Whitebrook, M., C. Howes, and D. Phillips. (1989). "Who Cares? Child Care Teachers and the Quality of Care in America. *National Child Care Staffing Study.* Oakland, CA: Child Care Employee Project.

Wulczyn, F. H. and R. Goerge. (1992). "Foster Care in New York and Illinois: The Challenge of Rapid Change." *Social Service Review*, 66, 278-94.

Wulczyn, F. and R. Goerge. (1990). *Public Policy and the Dynamics of Foster Care: A Multi-state Study of Placement Histories. New York, Illinois, and Michigan.* Chicago, IL: Chapin Hall.

© Child Welfare League of America 1997